PUBLIC HEALTH COUNCIL

Meeting of the Public Health Council, Tuesday, September 26, 2000, 10:00 a.m., Massachusetts Department of Public Health, 250 Washington Street, Floor 2, Boston, Massachusetts. Present were: Dr. Howard Koh, (Chairman), Dr. Askinazi, Mr. Manthala George, Jr., Ms. Shane Kearney Masaschi, Mr. Benjamin Rubin, Dr. Thomas Sterne, Ms. Janet Slemenda, Mr. Albert Sherman, and Ms. Phyllis Cudmore (arrived late approximately 10:20 a.m.). Also in attendance was Ms. Donna Levin, General Counsel.

Chairman Koh announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance, in accordance with the Massachusetts General Laws, Chapter 30A, Section 11A ½.

The following members of the staff appeared before the Council to discuss and advise on matters pertaining to their particular interests:
Ms. Louise Goyette, Director, Office of Emergency Medical Services, Dr. Bruce Auerbach, Vice Chair, Emergency Medical Services Advisory Board; Deputy General Counsels Tracy Miller and Carl Rosenfield; Mr. Richard Waskiewicz, Director, Food Protection Program, Division of Food and Drugs; Ms. Joyce James, Director, Ms. Joan Gorga, Analyst, and Ms. Holly Phelps, Consulting Analyst, Determination of Need Program.

RECORDS OF THE PUBLIC HEALTH COUNCIL MEETINGS OF MAY 23, 2000 AND JUNE 27, 2000:

Records of the Public Health Council Meetings of May 23, 2000 and June 27, 2000 were presented. After consideration, upon motion made and duly seconded, it was voted: unanimously (Ms. Cudmore not present to vote); That, records of the Public Health Council Meeting of May 23, 2000 and June 27, 2000, copies of which were sent to the Council Members for their prior consideration, be approved, in accordance with Massachusetts General Laws, Chapter 30A, Section 11A ½.

PERSONNEL ACTIONS:

In a letter dated September 5, 2000, Mr. Blake Molleur, Executive Director, Western Massachusetts Hospital, recommended approval of the reappointments of physicians to the consulting medical staff of Western Massachusetts Hospital, Westfield. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted: unanimously (Ms. Cudmore not present to vote); That, in accordance with the recommendation of the Executive Director of Western Massachusetts Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the following reappointments to the consulting medical staff of Western Massachusetts Hospital be approved:

REAPPOINTMENTS:	**RESPONSIBILITY:**	**MEDICAL LICENSE #:**
Joseph Keenan, M.D.	Otolaryngology	39737
William Dean, III, M.D.	Neurology	75273

In a letter dated September 7, 2000, Katherine Domoto, M.D., Associate Executive Director for Medicine, Tewksbury Hospital, Tewksbury, recommended approval of the appointments and reappointments to the provisional medical staffs of Tewksbury Hospital. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted: unanimously (Ms. Cudmore not present to vote); That, in accordance with the recommendation of the Associate Executive Director for Medicine of Tewksbury Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the following appointments and reappointments to the provisional affiliate and consultant medical staffs of Tewksbury Hospital, be approved for a period of two years beginning September 1, 2000 to September 1, 2002.

APPOINTMENT:	**MASS. LICENSE #:**	**CATEGORY:**
Theresa Cerulli, M.D.	152303	Provisional Affiliate
REAPPOINTMENT:	MASS. LICENSE #:	CATEGORY:
Jang Ho Cha, M.D.	151508	Consultant

STAFF PRESENTATION:

"EMERGENCY MEDICAL SERVICES 2000"

REGULATIONS:

Request for Approval to Promulgate Emergency Amendments to 105 CMR 170.000: Regulations for the Implementation of M.G.L. c.111C, Governing Ambulance Services and Coordinating Emergency Medical Care:

Ms. Louise Goyette, Director, Office of Emergency Medical Services, said in part, "…This formally starts the the process to implement the EMS 2000 law, which takes effect today. There are several new components that have been improved. Leadership is probably the most important one and we are starting that today with the two sets of regulations that you will be looking at. Other efforts to address new requirements of the Department and the EMS regions will have in planning are already underway. There are two very significant pieces in terms of the EMS community, and those are the service zone plans and the EMS First Response. Service zones are a mechanism created in EMS 2000 for local community planning…There's a whole new impact on local communities…We are involved now in a rather extensive educational process that we are doing with the EMS regions to roll this piece of the bill out, at least on an educational standpoint…EMS First Response was a late piece coming into the bill. There were some local issues raised. And in addressing those came the need to realize that First Response is an important integral component of the system. We wanted to recognize that. It is not only the newest piece in the law, but it is the least defined. We are pulling together at this point a small state steering committee to help us map out a plan and an effective strategy to make sure that throughout the process of developing regulations around the EMS First Response that we are getting a broad base of input from the entire EMS community and the consumer community as well."

Ms. Goyette continued, “The trauma care system is the piece perhaps which you may know the most about. It is the piece that is going to effect not only the pre-hospital, but also it has considerable impact on the hospital side, particularly those hospitals that choose to function in the capacity of designated trauma centers…Medical control is not new. We have a medical control structure in place. What EMS 2000 calls upon us to do is to ensure that the medical control system is a functioning substructure in every single component of the system. So it greatly broadens and intensifies the need for and the desire for clinical oversight in everything that we do, including EMS First Response, particularly around minimum staffing requirements, protocols which we have already put in place to this point. So we are going to be greatly enhancing that role. Communications and emergency medical dispatch, also an important piece. The EMS communication system is in great need of improvement and repair. We are already looking at that. We have re-instituted the statewide communications committee. Work is already underway to recognize the fact that the EMS communication system is an absolute key, essential component in our ability to monitor the performance of the EMS system overall. Toward that end, we have developed an internet-based system that is going to connect hospitals and ambulance services in real time. It will have a variety of applications but the primary reason for putting this together is the situation we have all been facing with hospitals having to divert ambulances because of crunches in emergency room departments and all of the factors that play into that. So we are ready to pilot that system starting mid-October. We are very excited about that because this winter we should be able at least to provide information in real time to both hospitals and ambulance services about that status. That is just as brief an overview of the new components as I can give you today.”

Dr. Bruce Auerbach, Vice Chair, EMS Advisory Board, said, “These are very exciting times for us in emergency medical services. There have been a tremendous number of changes which have gone through the delivery of emergency medical care, both in hospital and pre-hospital, over the last 25 or 30 years, since the last time the Commonwealth of Massachusetts passed on some EMS legislation. The problem is that the legislation, while it was somewhat visionary in its time, it has really not kept pace with all the changes that have occurred in the delivery of pre-hospital and emergency medicine and medicine in general. It was put together at a time when the system was very piecemeal. It was a lot of local services doing things. There was not nearly the capacity for communication that there is today. There were many issues in technology and

pharmacological administration in medicine which were not available at the time…The problem that has frustrated many of of us in Massachusetts over the last several decades has been the fact that the law that existed and the ensuing regulations really did not allow us to keep pace with that. The areas where we really needed to keep pace and what we needed to look for towards the future, are in areas of communication, integration, consistency in the delivery of care. And then the all important issue of data collection and monitoring and looking at outcomes…In this day and age where all of us are so concerned about how much money we spend on various aspects of health care, we cannot continue to do things, whether it's in the pre-hospital arena, in the emergency departments or anywhere else along the continuum of health care delivery, if they are not producing something that improves the health of the community or improve the health of the individual…EMS 2000 is creating a consistency and a uniformity so that any patient across the Commonwealth will get the same kind of care regardless of whether they are in the Berkshires or on the Cape or in downtown Boston. This is very important if we are going to be able to intelligently look at what we do and how effective it is…The issue of violence and injury prevention is an area that we consider very much within our purview. Again another issue that is very important from a public health perspective. The early identification of infectious diseases that are out in the community and how they are being dealt with, is another area very pertinent to the Public Health Council and the public health of the community. All of these things are in our vision for what EMS 2000 can enable…"

Representative John Stefanini said, "While the entire EMS community deserves a good pat on the back for all of their efforts, Senator Louis Bertonazzi and Representative John McDonough for starting this effort deserve a great deal of credit. I would also just mention Commissioner David Mulligan, Commissioner Koh, Donna Levin and David Harlow who did the drafting and early work on this. Louise and Brad and Nancy and the other folks really have put yeoman's effort into making this a reality today. All of the coalitions that have come together on this literally almost every stakeholder, be it a provider, a hospital, an EMS, private or public, the municipalities, the EMTs the paramedics, all come together. And a big chunk of what made that possible, was Commissioner Koh's leadership, David Mulligan's leadership, and the work of your staff. I think we are on the cusp of being able to better coordinate, consolidate and integrate our EMS services. That is a wonderful thing for the people in the Commonwealth and you should be very proud of that and the Council should be pleased. I want to add my congratulations for all the work you have done."

Council Member Sherman recognized and thanked former Senator Louis Bertonazzi for his perseverance carrying EMS into the 21st century.

Chairman Koh then said in part, "…I think most people in the Commonwealth do not realize that proper coordination of emergency medical services is a public health issue and a growing public health priority. The fact that we have this opportunity to integrate what we are doing statewide to make sure that a person from the western part of the state is getting the same service as a person from the eastern part of the state. To make sure, that a person in an emergency gets the right treatment, at the right place, at the right time. That's really the goal of the EMS 2000. We are off to an outstanding start here. These issues are very important in the changing health care climate, especially as hospitals close and there are fewer emergency departments. Many of you have heard about ambulance diversion issues, and that has come up over the last several winters. And it is already an issue this year, even before the cold weather has come. We have had discussions about better communications about diversions. Starting up an internet-based communication system so hospitals and emergency services know which facilities are on diversion, which ones are not…So many parts to this story and defining the service zones, integrating the trauma care systems. All the issues that Louise mentioned here are going to be critical to making public health work better in the future. So this is a really tremendous job that we should all be very proud of."

Attorney Tracy Miller, Deputy General Counsel, said in part, "Today is the day that EMS 2000 goes into effect…There are two sets of regulations before you today. One is a request for emergency promulgation and the other is an informational presentation of some additional amendments… The proposed regulations include a variety of different amendments that are the first step in what are going to be many steps to fully implement the statute…we are requesting the emergency regulations to ensure that there is no disruption in the provision of emergency medical services in the Commonwealth. We made them what we think is more user friendly, more friendly to both the regulated industry and the public…The other amendments that we have made, are the definition sections. We have now taken all of the definitions that were in the statute and incorporated them into the regulations. This provides the framework for all of the rest of the programs that are not yet established in regulation. But it does give us a complete framework. An additional section is the components of the state EMS plan. By statute, that state EMS plan has to be implemented within 15 months of today. That state plan then sets the

frame work for the five regional plans that will follow. The additional changes are a whole variety of amendments that either update or eliminate regulatory provisions that either are out of date or in conflict with the statutory language. Finally, there is one additional change that does not come directly out of EMS 2000 that are in the emergency regulations because of the fiscal crisis that the Office of Emergency Medical Services is facing at this point. And that is a provision that adds a certification fee for a very small group of EMTs that previously did not have a certification fee. That is EMTs that take a qualifying exam out of state or take a national qualifying exam and then seek certification in Massachusetts. As our current fee structure is established on a testing fee basis, those individuals who did not take a test in Massachusetts therefore essentially got a free certification. They did not pay for it. There are the same costs involved for the Office of Emergency Medical Services for certification of these individuals as there would be were they taking a Massachusetts exam. Therefore, we have by emergency regulation asked for a $75.00 certification fee for those individuals who are requesting certification on this basis. We are also looking into the future to restructure the entire fee structure. This is the first step that we felt needed to be done by emergency basis because of the current fiscal crisis that the Department is facing."

After consideration upon motion made and duly seconded, it was voted: unanimously (Dr. Askinazi not in the room to vote) to **approve the Request for Approval to Promulgate Emergency Amendments to 105 CMR 170.000: Regulations for the Implementation of M.G.L. c. 111C, Governing Ambulance Services and Coordinating Emergency Medical Care; That a copy be forwarded to the Secretary of the Commonwealth; and that a copy be made a part of this record as Exhbit No. 14,681.**

REQUEST FOR FINAL PROMULGATION OF AMENDMENTS TO 105 CMR 500.000, GOOD MANUFACTURING PRACTICES FOR FOOD:

The Department of Public Health, through the Division of Food and Drugs, is authorized to license establishments that engage in the business of processing or distributing food for sale at wholesale. DPH implements sanitary operating procedures and controls through a regulation entitled Good Manufacturing Practices for Food, 105 CMR 500.000. At the March 28, 2000 Public Health Council meeting, the Council voted for final promulgation of 105 MR 590.000, State Sanitary Code for Food Establishments, Chapter X. 105 CMR 590.000 will be filed with the Secretary of State and will become effective on October 1, 2000. The

residential kitchen section of 105 CMR 590.000 provides for only the retail sale of certain foods produced in residential kitchens that meet the regulatory requirements. Since the inception of the residential kitchen concept in 1991, the sale at wholesale of certain permitted foods was allowed. The revised 105 CMR 590.000 explicitly allows only the retail sale for residential kitchens. This coincides with the intent of 105 CMR 590.000 for all categories of retail food establishments. Comments received through the public hearing process advocated that wholesaling for approved foods should be allowed to continue.

At the July 18, 2000 Public Health Council meeting, Department staff informed the Council of its intention to revise its Good Manufacturing Practices for foods under restricted conditions. The Department also indicated its intent to bring the proposed draft to public hearing in August 2000. The Division wishes to report on the public hearing and to request approval for promulgation of the amendments to 105 CMR 500.000, Good Manufacturing Practices for Food. A public hearing was held on August 29, 2000 at the State Laboratory Institute, Jamaica Plain, MA. The proposed amendment was provided to all Local Boards of Health, interested state agencies and food associations. Comments were received from 7 parties during the public hearing and through the public comment period. The major part of the testimony was to offer support for the proposed changes to 105 CMR 500.000, Good Manufacturing Practices for Food. Several comments suggested changes in language. Strong support was provided by the Massachusetts Department of Food and Agriculture and the Massachusetts Specialty Foods Association.

After consideration, upon motion made and duly seconded, it was voted unanimously to **approve the Request for Final Promulgation of Amendments to 105 CMR 500.000, Good Manufacturing Practices for Food: that a copy of the approved regulations be forwarded to the Secretary of the Commonwealth; and that a copy of the amended regulations be attached to and made a part of this record as Exhibit Number 14,682. A public hearing was held on August 29, 2000 at the State Laboratory Institute, Jamaica Plain, MA.**

REQUEST FOR FINAL PROMULGATION OF AMENDMENTS TO 105 CMR 550.000, BAKERIES AND BAKERY PRODUCTS AND 105 CMR 595.000, LICENSURE OF VENDING MACHINE OPERATORS:

Mr. Richard Waskiewicz, Director, Food Protection Program, said, “We are requesting final promulgation of amendments to our bakery and bakery

product regulations, 105 CMR 550.000 and vending machine operators, 105 CMR 595.000. Our request is to rescind these two regulations. When the Public Health Council approved final promulgation of Chapter X, 105 CMR 590 for all retail food operations, within this context was the provision to allow retail sale of bakery products and of vending machine operations. All the appropriate sections of these two regulations were moved into Chapter X the State Sanitary Code. Therefore, these two regulations are no longer necessary. We held a public hearing on August 29th and received no comments for or against doing this. The Department is respectfully requesting the Public Health Council to approve final promulgation of the rescission of these two regulations, 105 CMR 550, bakery and bakery products, and 105 CMR 595, vending machine operators.

After consideration, upon motion made and duly seconded, it was voted: unanimously to **approve the Request for Final Promulgation of Amendments to 105 CMR 550.000, Bakeries and Bakery Products and 105 CMR 595.000, Licensure of Vending Machine Operators; That a copy be forwarded to the Secretary of the Commonwealth and that a copy be attached and made a part of this record as Exhibit No. 14,683.**

PROPOSED REGULATIONS:

INFORMATIONAL BRIEFING REGARDING AMENDMENTS TO 105 CMR 170.000: REGULATIONS GOVERNING THE EMERGENCY MEDICAL SERVICES SYSTEM:

Ms. Louise Goyette, Director, Office of Emergency Medical Services said in part, "…These regulations focus to a great extent on the leadership infrastructure to implement EMS 2000. And that falls on both the Department and also to a large extent, on the regional EMS councils. There are five regional EMS councils in the state. They are geographically separate regions. They are established as not for profit corporations. For the first time, they are established in the statute. They have been in place by regulation previously, but their important role in the delivery of emergency medical services is recognized by the statuatory language that is in EMS 2000. The regions are going to play an integral role of working with the Department in coordinating, overseeing and assessing the EMS system working with the various communities and their regions to establish service zones. The regulations begin by setting up a whole variety of things that were in place but they are now amended and added to, and they include such things as additional requirements for bylaws and the

council contracts with the Department. We spent a lot of time working with the regions in trying to set up the best interaction and the best structure. They also update the duties and responsibilities of the councils…"

Ms. Goyette continued, "The second aspect of the proposed regulations are the EMT certification fees. These are an extension and the first step to begin to move the fee structure away from a testing fee structure to a certification fee structure. This step then would establish for recertification of EMTs at both the basic and advanced life support levels, a fee of $75.00 every two years. Eventually the Department hopes to outsource the testing and then have an across the board certification fee of $75.00 for all EMTs. That will be presented over the next couple of years in amended regulation. There is another category that I would summarize as program administrative improvements that are in the proposed regulations. These include improved record keeping requirements on the part of the ambulance services and improved access to these records on the part of the Department. There are new provisions establishing confidentiality protection for patient medical information. And, the last category I would summarize, is advanced life support to 24 hours, 7 days a week. The current standard in our regulations is 8 hours, 7 days a week. Most of the advanced life support services in the Commonwealth already meet this standard. The regulations are going to provide a time period for adjustment. They will provide three years from either the time of enactment of the regulations or three years from initial licensure to meet that standard."

DETERMINATION OF NEED PROGRAM:

COMPLIANCE MEMORANDUM:

PREVIOUSLY APPROVED DON PROJECT NO. 1-1271 OF QUABBIN VALLEY CONVALESCENT CENTER – REQUEST TO INCREASE THE FINAL INFLATION-ADJUSTED MAXIMUM CAPITAL EXPENDITURE:

Ms. Joyce James, Director, Determination of Need Program said, "We are recommending approval of the capital cost increases requested by Quabbin Valley Convalescent Center. The cost increases are reasonable and could not have been anticipated at the time the application was filed and were beyond the control of the holder. For example, it was during the actual implementation of the project that the Town of Athol required the holder to purchase land adjacent to the facility site to meet zoning requirements and also to make significant changes to the on-site sewerage treatment plant. It was also during the actual renovation of the facility that

the holder discovered that parts of the building were badly deteriorated and had to be demolished and replaced, adding to these costs. Therefore, we seek Council's action on this proposed increase in the capital cost."

After consideration, upon motion made and duly seconded, it was voted: unanimously **to approve the Previously Approved DoN Project No. 1-1271 of Quabbin Valley Convalescent Center's – Request to Increase the final inflation-adjusted maximum capital expenditure** to $7,990,005 (February 1998 dollars). The MCE is for 48,770 GSF (18,715 in new construction and 30,055 in renovation). The project does not include addition of any DoN-exempt beds. The condition accompanying this approval is as follows: All conditions attached to the original and amended approval of this project shall remain in effect.

PREVIOUSLY APPROVED DON PROJECT NO. 4-3966 OF METROWEST MEDICAL CENTER – PROGRESS REPORT ON COMPLIANCE WITH CONDITIONS OF APPROVAL FOR TRANSFER OF OWNERSHIP:

Ms. Joan Gorga, Analyst, Determination of Need Program, said in part, "Since their last appearance before Council, MetroWest has undertaken and completed a community needs assessment. Now the local advisory boards and the board of directors for MetroWest Medical Center must take the needs assessment and develop its recommendations. On two conditions, transportation and governance, there continues to be a lack of agreement between the applicant and the Coalition. The needs assessment found that transportation was a significant problem and MetroWest has agreed to participate actively with others on a transportation task force. Staff has stressed in both progress reports that the shuttle issue must be addressed because the original DoN condition on transportation indicates that the applicant should provide a shuttle service between the two hospital sites. The applicant has continued to provide taxi vouchers for patients requiring transportation until the resolution of the issue.

On the issue of governance, the Coalition has noted concerns about the effectiveness of the local advisory board meetings. Since the local advisory boards are charged with making recommendations to the Board, staff has noted that the recommendations could provide a way to implement the results of the recently completed needs assessment. In conclusion, progress has been made in some areas of concern since the last progress report, for example in the area of mental health and

substance abuse, but other areas, such as expansion of free care and cultural competence are waiting recommendations based on the needs assessment. As noted in the staff summary, the Coalition has requested that MetroWest return in six months rather than one year. Staff is concerned that six months may not be sufficient time for implementation of the public processes required. Therefore, staff recommends that MetroWest be directed to submit a further update to the Council in September of 2001 on its progress in complying with all the conditions of its approved DoN Project No. 4-3966, and that staff be directed to report its findings to the Public Health Council. Staff expects to see more substantial progress in the next progress report and hopes that the next report will include further resolution of the transportation situation."

Next Mr. Lester Schindel, Chief Operating Officer, MetroWest Medical Center said in part, "…We are pleased to be able to share with you the results of the comprehensive community needs assessment of the MetroWest community. This report was recently completed in the summer and provides a wealth of information on the health care status of our community. With the completion of this study, we are now able to move forward with various planning programs and efforts with the hospital, with our advisory boards, and with our community organizations…Since Tenet purchased MetroWest Medical Center, we have been providing taxi vouchers between the two hospitals…It is not a large demand for services based on the movement and the amount of services available at each of the sites. We have also been working with the MetroWest transportation management agency, which is trying to pull together various community agencies and the overall community needs for transportation. And we believe there are better uses of funds to be involved with a more community global approach to transportation. As a health care provider to be in compliance with Medicare and Medicaid regulations, we have difficulty in picking people up at their homes and bringing them to our facility or to doctors offices because of compliance issues with Medicare/Medicaid regulations…In working through the transportation management agency, we are working with other community agencies."

Mr. Kevin McNamara, Member, MetroWest Community Health Care Coalition, said in part, "Thank you for letting us report on the progress of the MetroWest Medical Center sale…There are some concerns and issues that we feel that we need the Public Health Council's support to ensure that the hospital continues to work with us and include the community in establishing that the needs of the community can be met…We are committed to working with the hospital and would like to report that we are working together on these issues…I would also like to report that we are

happy that in meeting with the hospital, Tenet is preparing to create some task forces and involve the community in meetings on some of the issues in mental health, indigent, free care, transportation and elder health…One of our major priorities was that governance be something that involved the community process, with input. We felt the advisory boards were extremely important to get the community's input, to get a real sense of what the community needs were…The transportation issue was also a very clear concern of the Coalition. Most of us are working with people who do not have adequate resources to get their health care, and it is very important that they have access to transportation. Regarding free care, Tenet was supposed to set up a process involving the community to see whether to expand services that were covered by free care, which is a major concern of ours. We are very committed to working with the hospital around these issues, to try to develop a sense of where the community is at and how we can best help health care services to be delivered to our community…"

Representative John Stefanini of Framingham said in part, "I have been active in health care policy for a dozen years and have visited and been part of numerous facilities. Tenet has offered a facility better than either of its predecessors. They have appointed board members that are genuine community representatives…people who are vocal in the community, people that are part of the community. They have been very aggressive in responding to the homeless. They have hired a physician and a nurse practitioner to reach into the homeless community and deal with those issues. They have gone into the poorest elementary school district and set up a clinic. They have had enormous dialogue in terms of relocation of the South Side Clinic. In my assessment, they reached out and they added everybody and anybody who asked to be part of it…I think that the Coalition needs to expand and broaden and become more engaged with the hospital and that the hospital has to engage in the broader community as well…I am committed to working with the Coalition and the hospital to make that happen…On the issue of transportation, I've lived in this community my entire life. I represent the community. The shuttle bus is a mistake. The DPH staff said it was a mistake…The voucher system they set up might not be the way to do it, but there is an extensive lift bus, local inter-Framingham transportation system. The hospital is committed to come up with serious dollars to funnel into that, and to expand it so that it does the shuttle service, but it does more than that so you do not have two isolated locations. You have doctors offices and clinics and other things as part of that. The shuttle service might work great for a few people, it will not meet the needs of the indigent community in that area. I think

everybody needs to take a step back and be a little more open minded and creative and work together to its common goal. We have made much progress and there is a lot to do, but working together is the only way we are going to do that."

Ms. Grace Ross, Sister's Together Ending Poverty, said in part, "…One of the major reasons I came to speak today is that people were not part of participating in the completion of the needs assessment. Members of our group have tried to access free care…Essentially free care in our hospital system is meaningless for the folks who need it…I have been approached by a number of people who cannot access free care anymore. As far as they are concerned, they have no access to medical coverage because their families are not eligible for Mass. Health for various reasons and free care is meaningless for them because they cannot afford it. So this concerns me the most. I think it's a serious concern, particularly given that I have now seen the report both from the needs assessment and the Coalition's response to it saying that no one really did a lot of assessment around what is happening with free care. There were three things we were very concerned about in the original agreement. One was free care, one was the translation services, and one was the issue with contracts with workers. There have been some real problems with some of the contracted union issues…So, I can only raise those concerns and I raise them partly because if feels to me like I see the tip of the iceberg. I am a community activist. To me this issue about the free care is excruciatingly important, and I don't know what to do about the fact that it is meaningless for a lot of the families that we work with."

Council Member George said, "I sense they have made a great deal of progress but I think it's really important that they continue to inform us of that progress, and continue to work out the areas of communication. I think everyone is well intended, the hospital representatives, the Coalition and the rest. I think it would be helpful, we may be able to play a role in this by having them in six months report back to make sure everything is pretty much on target."

Chairman Koh announced that due to a strong concensus from the Public Health Council, six months would be an appropriate follow up time to see how communication is going. **NO VOTE – to return in six months.**

CATEGORY 2 COMPLIANCE MEMORANDUM:

PREVIOUSLY APPROVED DON PROJECT NO. 1-1300 OF EDGECOMBE NURSING HOME – REQUEST TO DECREASE THE NUMBER OF BEDS, GROSS SQUARE FEET AND INFLATION-ADJUSTED MAXIMUM CAPITAL EXPENDITURE:

Ms. Joyce James, Director, Determination of Need Program, said in part, "…We are recommending approval of the proposed amendment to the Edgecombe Nursing project. The amendment meets the Determination of Need regulations for significant changes. We also believe that downsizing the project is a fiscally sound decision, given the distressed financial situation in the industry and also the number of competing nursing facilities in the area. The downsizing also addresses concerns raised by the Ten Taxpayer Group about the facility's expansion when the application was originally filed…Comments were submitted on the proposed amendment which relate primarily to the anticipated closure of the nursing care center at Kimball Farms. These comments are really not relevant to the proposed amendment and we are constrained by the Determination of Need regulations to focus on the subject under consideration, which is the proposed amendment. The anticipated closure of the nursing care center at Kimball Farms is a separate issue. Furthermore it is part of the institution's strategic plan, which does not mean that it will occur. Therefore, we must continue to recommend approval of the subject under consideration, which is the proposed amendment to the Edgecombe Nursing Home project."

Attorney Carl Rosenfield, Deputy General Counsel, said in part, "…I have one thing I want to clarify. The Applicant already had a DoN for renovation. They decided to downsize that project and the downsizing is of sufficient scope to trigger need for a significant change. They indicated that one of the things that they were planning for was to accommodate their life care commitment to Kimball Farms, because they were planning to close the nursing unit there. So, people, instead of going to the Kimball site, would go to Edgecombe. But, in fact, that representation is background information. It is not relevant to consideration of the application to downsize the project at Edgecombe. We are not unmindful of the fact that there is a dispute involving the potential closing of Kimball Farms…We want to be very careful to note that by approving this project, you would in no way be taking the position one way or another on the

proposal for Kimball Farms. So nothing we do today here should be construed as an approval of their proposal, nor should it be indicating a disapproval as well. It's just a separate process. If Kimball Farms is closed, it may be that later on through the licensure process there are relevant issues for the Department. There also may be relevant issues for consideration by the Attorney General…So there would be other avenues that would be more appropriate for them to address whatever grievances they have."

Attorney Robert Griffin, Attorney for Krokidas and Bluestein, said in part, "…I am here on behalf of the Edgecombe Nursing facility…We support the staff recommendation. The only reason we are here today is because we are seeking an amendment to downsize the facility…However, certain issues have been raised and we would like to address them. The residents go both ways on this Kimball Farms issue, which really is an outside issue. Generally, in this context people would comment upon the size and scope of the project being reduced and how that is good for the Commonwealth. It will result in Medicaid savings because it will be less Medicaid money going into supporting the capital cost structure in a nursing facility. The staff points out that the reduction in size is fully consistent with your statutes and your regulations, guidelines, because downsizing will achieve a better allocation of health care resources at the lowest reasonable aggregate cost...And, ironically, if the Department were to disapprove the significant change, my client would be in a situation of acting on its original DoN, which would put us in an incongruous position of spending more money than would be necessary, which seems to be at odds with what the Department and the DoN program stands for. As for the comments submitted, they don't really go to the general DoN type issues. They talk around who will be the residents possibly at the facility afterwards. On the whole we agree with the staff that they are not germane to the issue that is before you. There was one comment that said that the proposal will result in a substantial change in service, and we respectfully disagree with that position…Furthermore, we are not changing services, we are just reducing the size. So that has never been a trigger for a full DoN. In fact, the DoN regulations fully support this proposal. Now there is one area in which there is general agreement. Based upon comments made by staff…is that we all agree that this is wholly independent from Kimball Farms. We are not here today seeking any kind of approval dealing with Kimball Farms, which is a separately licensed facility. We are here seeking approval of a reduction in capital expenditures and reduction of bed size…We would like you to view this favorably…We seek your approval."

Attorney Sherwood Guernsey, representing the residents of Kimball Farms, said in part, "…The Public Health Council has a very crucial role in protecting and ensuring those who are most vulnerable, the young, the elderly…Berkshire Retirement Community, Inc., which is otherwise known as Kimball Farms, plans and has voted to replace the nursing care center at Kimball Farms with Edgecombe. This application is basically, in major part, phase one of the Kimball Farms closure. They cannot close the Kimball Farms without having some place to put the residents, therefore, Edgecombe is in the picture because it happens to be within a mile…The staff in their report, indicates that there is no evidence of the Kimball Farms closing in the record. With due respect, that is just not the case…On July 15, 1999, the vote of the trustees of Berkshire Retirement Community…voted, indeed, for that closure. 'The Kimball Farms Board of Trustees agrees to move its licensed nursing care center to an alternate site in Lenox, presently Edgecombe. This nursing care center should bear the Kimball Farms name.' The Kimball Farms name! And they are trying to say that this is not going to be a transfer? I find that hard to believe, but in any case, '…and to have at least 15 private rooms with semi-private rooms larger than the present on site nursing care center…' and it goes on. But that was the vote and that is on the record. Now in addition, I would ask you to look at Mr. Carlson's statement of opposition. The last three pages there is a copy of a memorandum from William C Jones, Senior Vice President and Albert Ingegni, III, Interim Executive Director, February 2000. I would direct your attention, 'Following construction, Edgecombe ownership will be transferred to Kimball Farms…at value to be determined by an independent appraisal required by Kimball Farms board…' It's a merger, it's a transfer of assets, it's a sale. There will be bottom line transfer. That is what is going to happen. That's what is being said here."

Attorney Guernsey continued, "It also happens to add that, "…Regular and easily accessible transportation to and from Edgecombe is essential to the success of the plan…" The important thing to the success of Kimball Farms was already put in place, just as we had hoped and intended that the visionary work of Berkshire Health System originally would do, and that is to have one unified care center there at the beginning. And we hope that will be retained. So, I think it's clear that the issue of the Kimball Farms' closing is on the record, and that makes this process very importantly different. On that basis then, there is an avenue here that requires your attention. That because the Kimball Farms Nursing Care Center will be replaced by Edgecombe, that is a major part of this application. Then that replacement, with a construction cost of over $4 million, requires a full DoN review. This is a replacement. The people at Kimball Farms will no long be able to use that nursing home. Secondly,

because this represents a substantial change in service there will be more than a 12 bed increase, because of the replacement. One more trigger for the DoN review. And finally I want to add that this replacement is in violation of Kimball Farms' original application, which is replete with the value, the importance of having the continuous care on one site. So there are several bases for requiring a full DoN review. We ask you to defer action on this amendment in order to consider or require a full DoN. …In the alternative, if you desire to approve this amendment so that they can go forward and spend less money, then we would suggest that you put on a condition that would make the amendment, as approved, subject to the condition that prior to the Kimball Farms closing a full DoN be required. That is to respond to the issue that has been raised, even though there is a vote, even though they are talking about transferring for value, even though that is the plan…Three or four final points. The holder argues that they could have gone forward under the original application. So why bother with us? A couple of responses. They did not. We did not initiate this process, they did. They filed the amendment. Since the original, now at the time of the filing of the amendment, very new and important facts have come up. And those facts are that we now know, from the votes, that there is a plan to close the Kimball Farms Nursing Care Center. That's a very new fact, and very important…"

Next, Reverend Evor Roberts, a resident of Kimball Farms, said in part, "…When we arrived at Kimball Farms we felt that we had sailed into a safe haven for the remainder of our lives. Kimball Farms marketing had persuaded us that on-site life care was the best long-term health insurance that we could buy. And we had committed our future and all our assets to our new home. The very next month, we learned that our board of trustees was seriously considering the splitting of our life care community. The sick and weakest among us would be maintained in another place on the other side of Lenox. I wrote a letter addressed personally to each Board member urging that they not fracture our community by the abandonment of an on-site skilled nursing facility…On July 15, 1999, the residents were called to a special meeting with the Board and informed that their decision to close our nursing care center was final. As of today, that decision remains unaltered. My special petition to you, members of the Council, is that you focus on the heart of this issue…I had realized that from the outset that Kimball Farms was going to be our home. Indeed our last home. It should be a safe haven to our end time that every resident has contemplated…We implore the Public Health Council to ponder and to use its authority to prevent the Berkshire Healthcare System from depriving us of our on-site life care security."

Attorney Carl Rosenfield, Deputy General Counsel, said, "First, let me reiterate that we are not unmindful of the fact that this is a very serious concern to the residents of Kimball Farms…What you have recently heard is a very novel presentation or an interpretation of a DoN laws as it relates to this project. First let me say that there is no prohibition in the CCRC guidelines on providing life care commitment in an off site location. In fact there is some language that acknowledges that it is a possibility. Number two, there is no DoN trigger here for replacement of Kimball Farms. At best that replacement is a contingency that may or may not occur…We look at this as a DoN amendment for the reduction in size of the Edgecombe project. However, if after that is granted there is a subsequent decision to transfer ownership of Edgecombe Nursing Home to another related entity within the system, the licensing Department would review that under its existing licensing requirements for long term care. So unlike hospitals where there is a requirement for DoN review where there is a transfer of ownership, in the case of nursing homes, that is totally a matter of licensing with no DoN review associated with the transfer of ownership. However, there is a very rigorous process for scrutinizing those transfers of ownership and assuring that the new owners are suitable. So that would be the way in which we look at this from a legal perspective. The Edgecombe amendment is a separate process. There is no requirement for DoN review beyond consideration of the downsizing of the project. Any subsequent transfer of ownership involving Edgecombe and with Kimball Farms Corporation would be reviewed by the Department under its licensing processes…"

After consideration, upon motion made and duly seconded, it was voted unanimously to **approve the Request of Previously Approved DoN Project No. 1-1300 of Edgecombe Nursing Home, (summary of which is attached to and made a part of this record as Exhibit No. 14,684) based on staff findings, to decrease the number of beds, gross square feet and inflation-adjusted maximum capital expenditure.** The approval provides for 74 Level II beds, 32,768 gross square footage of substantial renovation, and an inflation-adjusted maximum capital expenditure of $4,039,673 (June 2000 dollars). The project does not include addition of any DoN-exempt beds. The breakdown is as follows:

Land Costs:	
Site Survey and Soil Investigation*	-
Total Land Costs	-
Construction Costs:	
Depreciable Land Development	$ 96,500
Construction Contract (including bonding cost)*	3,239,668
Fixed Equipment not in Contract*	
Architectural & Engineering Costs*	
Net Interest Expense During Construction	265,725
Major Moveable Equipment	340,652
Total Construction Costs	$3,942,545
Financing Costs:	
Costs of Securing Financing	97,128
Total Financing Costs	$ 97,128
Total Estimated MCE	$4,039,673

*Included in construction contract

This amendment is subject to the following condition:

All conditions attached to the original and amended approval of this project shall remain in effect.

CATEGORY 2 APPLICATION:

PROJECT APPLICATION NO. 6-3982 OF NORTH SHORE MEDICAL CENTER – UNION HOSPITAL – ADD A 17-BED GEROPSYCHIATRIC UNIT:

Ms. Holly Phelps, Consulting Analyst, Determination of Need Program, said in part, “North Shore Medical Center, Union Hospital, which was formerly named Atlanticare Medical Center, is proposing to establish a 17-bed geropsychiatric unit. They were granted a 308 exemption last August 1999. Staff finds that the project meets the guidelines for adult psychiatric services, and further that it enables the applicant, North Shore Medical Center, Union Hospital a/k/a Atlanticare, to comply with the conditions of approval of its transfer to North Shore Medical Center several years ago. The Leslie Greenberg Ten Taxpayer Group registered in support of the proposed service on the condition that the applicant apply to Mass. Behavioral Health Partnership so that with the provider status through

them the service would be accessible to Mass. Health patients. The applicant agreed to that condition…The staff is recommending approval of the project…"

Dr. Paul Summergrad, Vice President, North Shore Medical, said, "Basically this unit has been operational since last August. It has reached out to members of the Lynn community. We have been receiving admissions both from physicians, nursing homes, other extended care facilities, and from the general community over that time. The census and the demand for services has been robust and we have taken care of patients with combined psychiatric medical and substance abuse disorders. And as a consequence of this, which was unexpected, we have been able to re-establish a presence for psychiatry at Union Hospital, which has allowed a growth of psychiatric consultation and emergency services. We are now providing consultation on medical/surgical units at Union Hospital to over 50 or 60 medical/surgical inpatients per month. We think that this is a critical important program. We are eager to have a contract with Mass. Behavioral Health Partnership both for geriatric services and for adult services at Salem Hospital…"

Next, Ms. Leslie Greenberg, Lynn Health Task Force, Ten Taxpayer Group, said, "As Chair of the Lynn Health Task Force for fifteen years, I have had the opportunity to advocate for quality, accessible and affordable health care in the Lynn community. The task force has been concerned about the lack of mental health services in our area, and we have been working actively with North Shore Medical Center and Union Hospital to try to remedy the situation. Last year we were more than happy to send a letter of support in favor of the 17 bed geri-psych unit at Union Hospital. Our concern is about the availability of these services to low income seniors who might need them. While the hospital does serve the Medicare population, it does not have a contract to serve those who only have Mass. Health. The Lynn community has an ever growing population of immigrants who have little or no work history in this country. This problem also affects seniors with disabilities. Although a lot of these people do qualify for Mass. Health, they are not able to get these services at this time at the geri-psych unit because of the fact that their only insurance is Mass. Health, and it does not seem fair to them. The hospital officials have agreed that they would seek the Mass. Behavioral Health Partnership contract. So therefore, I respectfully request that the Public Health Council adopt the staff's recommendation and follow up on the hospital's compliance with the conditions for the approval of the DoN."

After consideration, upon motion made and duly seconded, it was voted: unanimously (Dr. Askinazi and Dr. Sterne recused) to **approve Project Application No. 6-3982 of North Shore Medical Center-Union Hospital**, (summary of which is attached to and made a part of this record as **Exhibit Number 14,685**), based on staff findings, with a maximum capital expenditure of $473,372 (June 2000 dollars) and first year incremental operating costs of $2,921,039 (June 2000 dollars). As approved, the application provides for addition of a 17-bed geropsychiatric unit.

This Determination of Need is subject to the following conditions:

1. The Applicant shall accept the approved maximum capital expenditure of $473,372 (June 2000 dollars) as the final costs figure except for those increases allowed pursuant to 105 CMR 100.751 and 752.

2. The gross square feet (GSF) for this project shall be 13,579 GSF for renovation.

3. The Applicant shall, upon project implementation, submit signed formal affiliation agreements with hospitals, nursing homes, assisted living facilities and home health care agencies which document a continuum of care including discharge and referral sources.

The Leslie Greenberg Ten Taxpayer Group (TTG) registered in connection with this project and submitted comments in support of the project.

The meeting adjourned at 12:30 p.m.

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Howard K. Koh, M.D., MPH
Chairman
Public Health Council

LMH/sb